World Vision, Inc.

World Vision Kenya
First Annual Report
Teso Child Survival Project Implementation Report
Teso District, Kenya
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Abbreviations

AKHS-CHD	-	Aga khan Health Services-Community Health Department
Afri- Afya	-	African Network for Health Knowledge Management and Communication
AMREF	-	African Medical Research and Education Foundation.
BCC	-	Behaviour Change and Communication
BDMI	-	Bungoma District Malaria Initiative
CBO	-	Community Based Organization
CORPs	-	Community Own Resource Persons
CHW	-	Community Health Worker
CS	-	Child Survival
CSP	-	Child Survival Project
CSTS	-	Child Survival Technical Support
DCH	-	Division of Child Health
DC		District Commissioner
DHC	-	Dispensary Health Committee
DHMB	-	District Health Management Board
DHMT	-	District Health Management Team
DMOH		District Medical Officer
DIP	-	Detailed Implementation Plan
DoMC	-	Division of Malaria Control
HFA		Health Facilities Assessment
HH/C IMCI	-	House Hold/ Community Integrated Management of Child Hood Illness
HMIS	-	Health Management Information System
HIS	-	Health Information System
FHI	-	Family Health International
IEC	-	Information Education Communication
ITN	-	Insecticide Treated Net
IMCI	-	Integrated Management of Childhood
IPT	-	Intermittent Presumptive Treatment Illnesses
MOH	-	Ministry of Health
PHO	-	Public Health Officer
PMOH	-	Provincial Medical Officer of Health
PSI	-	Population Services International
RBM		Roll Back Malaria
SP		Sulfa and Pyrimethamine
VHC	-	Village Health Committee
VCT	-	Voluntary Counseling and Testing

1.0 INTRODUCTION.

PROJECT GOALS/OBJECTIVES AND INTERVENTIONAL ACTIVITIES

The overall goal of the Teso CSP is to achieve sustained morbidity and mortality reduction among children aged below age five and Women of Reproductive Age (WRA).

1.2 OBJECTIVES AND TARGETS

The project seeks to reduce

- To reduce malaria-associated morbidity and mortality in children and pregnant women through improved case management of malaria and pneumonia, malaria case ante-natal chemo-prophylaxis, and the promotion of ITNs and their re-treatment. (25% Effort)

- To reduce HIV transmission in WRA and their infants through strategies for behavior change that will include increasing women's confidence and skill to negotiate risk reduction, surveillance and treatment of sexually transmitted Infections (STI), strategies to reduce risk of STI transmission, and ensuring that a low cost supply of condoms is readily available. (25% Effort)

- To reduce infant and child morbidity and mortality through strategies that will increase full immunization coverage for children before their first birthday, tetanus toxoid immunization for pregnant women and distribution of Vit. A. (10% Effort)

- To reduce pneumonia associated infant and child mortality through strategies that address prompt and appropriate ARI and pneumonia case management (PCM) at the health center and community levels, household recognition of danger signs, timely care-seeking behavior and treatment compliance. (20% Effort)

- To reduce diarrhea-associated morbidity and mortality through effective household preventive behaviors and improved case management. (20% Effort).

1.3 PROJECT STRATEGIES/APPROACHES

The project has identified and uses various strategies that center on building the capacity and addressing the sustainability of child survival initiatives in the district. These include:

(i) Strengthening the capacity of local partners at the district level (DHMB, DHMT, Health workers, health committees) for improved

management of district health services, including:

- HIV/AIDS & STI prevention & management
- Malaria prevention & management
- EPI coverage & Vitamin A supplementation
- Pneumonia Case Management
- Control of Diarrhea Diseases

(ii) Strengthening capacity of local partners to implement household and Community IMCI.

(iii)Training, Support & Follow up for skills in:

- Participatory Learning & Action
- Quality Assurance
- HMIS strengthening
- Gender Awareness.

(iv) Through Participatory Learning and Action (PLA) exercises enabling communities to identify their own strengths and constraints to better health, to utilize local resources, and to actively participate in outreach services and take action for health promotion and health management.

(v) Partnering with MoH (local and national), Institutions and other NGOs for technical support in project implementation.

2.0 PROJECT ACTIVITIES: ACHIEVEMENTS & CONSTRAINTS

2.1 Baseline for project implementation activities.

Project implementation activities commenced during the second quarter of the FY 1. The initial activities included conducting the KPC, qualitative studies and HFA baseline surveys. These were carried out during the 2nd quarter and part of the 3rd quarter (report compilation). The DIP was completed during the same period. These activities provided information for project planning, monitoring, orienting project staff and district level stakeholders.

Key achievements include an assessment of the DHTs, DHMT, DHMB, Health Facilities Committees and providing training on health planning for health workers and DHT members.

The DIP that was prepared in a participatory process that involved a wide range of stakeholders and led by a child survival specialist consultant. The Chief, Child Survival Division, BHR/PVC, Sheila Lutjens, visited the project during the DIP stakeholder workshop.

Factors that contributed to program achievements include:

- Providing technical reference material provided by the CORE/CSTS on KPC baseline survey guidelines, DIP preparation, C-IMCI, CS Technical Reference Materials and the BASICS HFA tools. The project staff and stakeholders referred to these in the preparation, implementation, analysis of the baseline surveys, and compilation/preparation of the DIP.
- The project received extensive technical support from the WVUS program officer during the process.
- The project staff established an effective working relationship with the district stakeholders within a very short time. This ensured that that all stakeholders took ownership of the project.
- Collaborative partnership established with partner agencies AMREF-BDMI, CISCS,AKHS and JHPIEGO, for technical support.

The project was also faced with a number of challenges:

Support systems, including financial systems, logistics and office facilities were not in place when the project began activities. This presented a number of challenges to conducting and analyzing the baseline studies.

- Office space promised by the DHMT was not suitable for occupation at the beginning of the project, and no other facilities are available to rent. Factors outside of the DHMT's control, such as obtaining electrical and telephone hookup, delayed promised improvements. This problem still remains at the end of the first project year. Project implementation staff had not been oriented about Child Survival activities when program activities began. The project team had to find other ways of acquainting themselves, partly through the technical reference materials from the CSTS/CORE group as well as through collaboration with partners namely AMREF-BDMI, Care Siaya CS, Aga Kahn and JHPIEGO.

2.2 The DIP

The DIP was developed in a participatory workshop, including district stakeholders, WV (K) staff and staff from partner agencies. The participants identified activities, objectives and targets for each of the interventions. Following submission and consultations with USAID in June 2002, a number of changes were made in the five-year plan, the training plan, the security plan as well as overall project M&E plan.

The budget was also revised to (I) Facilitate the implementation of the IMCI approach as opposed to the originally proposed SCM for malaria and pneumonia , and (ii) Enable the project to hire four additional staff, Community Development Motivators, who are expected to function as a link between the project and community. (All other technical staff are not

from the district the revised sections of the DIP are included in the annexes)

How the DIP is used

The WV Teso CSP staff in partnership with the stakeholders comprises the project implementation team. The project implementation team reviews the DIP activities and objectives in relation to the budget. Spending is matched to actual activities.

The DIP document was developed in partnership with other stakeholders, and the revised DIP document has been shared with them.

Project planning is done on a quarterly basis and plans are drawn up in relation to the objectives. This process has helped the project staff to understand and interpret the DIP and use it.

All reports are tracked according to project objectives. The project staff prepares and submits monthly and quarterly reports.

Financial reports are also prepared on a monthly basis and they are based on the project objectives. This gives an opportunity for more detailed analysis and re-planning. The project and partners have jointly developed the FY2 annual plan based on the DIP. This plan is included in the attachments.

2.3 Strengthening the capacity of local partners at the district level (DHMB,DHMT, health committees) for improved management of district health services.

In order to implement child survival activities in the district, the capacity of structures and groups in the district needed to be developed, either directly or indirectly. To meet program objectives, the Teso CSP has identified the DHMB, DHMT, Chiefs, and Health facility Committees as the target groups for specific training. Since that time, the CSP conducted a number of training workshops in partnership with other agencies.

(i) DHMT training

DHMT training was conducted with a focus on the roles and functions of the DHMT. The five-day training (04/ 22/02-04/26 /02) was held in collaboration with officers from the PMOH and the Division of Health Care Financing from the national MOH. The training resulted in the development of the first District Health Plan focusing on team formation and strengthening management procedures per MOH guidelines. This training was the first of its kind since the district was created. , The team

acknowledged the training was very significant in contributing to the improved functioning of the DHMT and enabling them to respond better to health needs in Teso.

The DHMT embarked on developing a district health plan which is still in progress. Indicators for monitoring the functioning of the DHMT have not been developed yet due to the high DMOH turnover. In addition, the WV Teso CSP HIS coordinator has just joined the project and he is still finalizing some of the project M&E plan.

(ii) Training of DHMB and Hospital Board-(Alupe)

A five-day workshop (05/27/02-05/31/02) was held in collaboration with the PMOH (Western province) and MOH Division of Health Care Financing. As Community representatives, the boards were constituted by the MOH and charged to oversee health services in their districts. The majority of board members do not have a health or medical background. The five-day workshop provided an opportunity for the DHMB and Hospital Management Board to acquire the relevant knowledge and skills to effectively function in their roles.

Some of the topics covered were: HSR, roles and functions of DHM and lessons learned from other districts. Eighty-five percent of the board members attended the training. Indicators for measuring the functioning of the board are in the process of development.

(iii) Training of Chiefs and Assistant Chief

Chiefs were trained in a one-day workshop held on 9th May 2002 in collaboration with the DC's office. Topics centered on strengthening the chief's to manage community development and support activities. This provided an opportunity to mainstream Child Survival activities into community development activities, thereby contributing to project sustainability and ownership.
98% of the district Chiefs and assistant chiefs attended the workshop.

(iv) Training of Health Facility Committees.

Health facility committees play an important role in the functioning of the health facilities and the communities they serve They provide a forum where both groups can collaborate. A total of 11 health facilities in the district have health facility committees (The other two are hospitals with hospital boards).
Committees were assessed and gaps in training and function were identified. The training has not started. (The target is to have 100% trained).

This is related to the following factors:

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- There seems to be a misunderstanding between the committees and the MOH. Currently, there are plans to resolve these differences through a dialogue between the MOH, Committees and the Community. In addition, the CSP gathered information and experience from the AKHS on the criteria and strategies for mobilizing and empowering health facilities through the "DHC Model"[1] and approach which will be adapted for Teso District through the established partnership with the AKHS-CHD
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- The CSP staffing levels were not sufficient to take on this role more actively this year. The focus has been on building the capacity of the community and health workers. With the addition of four more staff, community motivators, and given that the capacity building strategies for health workers are now in place, this aspect will be given more attention in FY2.
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- In addition, the CSP has been conducting community mobilization for child survival activities to enable the community to make decisions about the health facility committees that are more informed.
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- Indicators for monitoring this activity are still in the development process.

2.4 Strengthening the capacity of local partners at the district level (health workers) for improved management of district health services in HIV/AIDS & STI prevention & management.

2.4.1 Support the district to strengthen HIV/AIDS/STI surveillance system:

The baseline survey revealed that the district lacked important information on HIV/AIDS STI prevention and care at both the facility and community levels. The CSP, in partnership with NASCOP and the DHMT, facilitated the training of five key MoH staff/officers on HIV surveillance. Following the training, the district was recruited as one of the national HIV sentinel sites. This is an area for anonymous testing in the country. Through this initiative, it is hoped that a link will be established between the district and the national HIV/AIDS/STI plans, activities and technical supervision. HIV

[1] MOH GOK, Aga Khan Health Services (K) Community Health Department –"Managing a Dispensary", A Participatory Model.

surveillance activities in the district commenced in June 2002 and the first report was expected in September 2002.

The district still lacks the capacity to surveillance activities and still relies heavily on the national surveillance program, NASCOP, for technical guidance and support. Though the CSP has continued to play a pivotal role in creating linkage between the NASCOP and the district, this has not yet resulted in adequate technical support from the national level to the district. Although data and samples were collected and forwarded to the national NASCOP, the analysis is completed but the report has not been received. The CSP is working with the DHMT to develop indicators to measure progress in this activity.

2.4.2 Support district to establish VCT Centers:

HIV counseling and testing is one of the key pillars for establishing an effective HIV/AIDS prevention and care program. When an individual knows their HIV status, they are in a much better position to make informed choices regarding their lives. The district does not have any VCT centers.

The CSP has embarked on activities to support the district in establishing 2 VCT centers. In line with this objective, the CSP initiated partnership dialogue with the KAPC and FHI in order to mobilize more support for the initiative. FHI have already indicated their willingness to partner with the CSP in staff training for those who will work in the centers as well as provide technical support in to the centers. The KAPC will provide the technical input in the staff training.

2.4.3 Facilitate establishment of community-based responses for HIV/AIDS care and support.

The main activities planned here were having PLA sessions with target groups on HIV prevention skills, as well as identifying mechanisms for care and support, through the community based structures/network of VHCs, CHWs and other CORPs.

Currently, the CSP is still in the process of establishing/developing this network. However, the CSP has also initiated the process of developing a district health promotion strategy that will be used for the BCC framework. In the meantime, the project staff share HIV AIDS prevention messages with the community during the community mobilization activities as well as other opportunities that arise.

2.5 Strengthening the capacity of local partners at the district level (health workers) for improved management of district health services in Malaria prevention & management.

2.5.1 Improve the skills of health workers on Malaria Case Management

To achieve this, the CSP, in partnership with DCH-MoH and AMKENI Project, planned to train the health workers using the IMCI strategy. To date 29% of health workers in one facility (6% of total number of facilities) have been trained in SCM. The CSP is negotiating with MoH on training of CHWs for home case management for malaria through the provision of first line antimalarials.

2.5.2 Improved care-seeking behavior.

CSP has continued to share messages on malaria care seeking behavior, management and prevention. This has been through community mobilization forums as well as other community activities. This will be strengthened with the involvement of CHWs and other CORPs, within the HH/C IMCI initiatives

2.5.3 Malaria prevention using ITNs.

The CSP seeks to promote the use of ITNs by the vulnerable groups- pregnant women and children aged less than 5 years. The project strategy is to empower women to market ITNs as well as share messages with their neighbors on the benefits of using ITNs in order to develop a net culture.

The CSP, in partnership with other stakeholders, developed criteria for the selecting women's groups based on lessons generated from AMREF-BDMI project and World Vision Bunyala PHC. Twenty-four groups were identified and selected and will be trained and given ITNs for marketing, over the period September 2002- June 2003. This represents phase I of the ITN marketing strategy. Phase II will target other groups but will also incorporate lessons learned during phase I. The goal is to have a total of 24 groups spread out in the district during this phase.

The training is being undertaken in partnership comprising WVK, MOH, Ministry of Culture and Social Services, Ministry of Cooperative Development Women groups and PSI.

The training topics include Introduction to Family Practices for CS initiatives, Malaria Control, through use of ITNs, Book keeping, and Community Mobilization among others.

Achievement level (Phase I).

Eight (33%) groups have been trained and will be issued ITNs during the first quarter of FY 2003.

However, there is still need to explore other innovative ways of net delivery to ensure equitable access to nets by vulnerable groups due to the cost implications.

The CSP has developed M&E tools that will be used to track progress.

2.5.5 IPT

Activities have not commenced here as planned. Initial assessment at the ANC clinics indicated that although the health workers had the guidelines, they were not implemented, due to irregular availability of SP drugs. The CSP is exploring other ways of addressing the issue. Already, there is dialogue already established with JHPIEGO and DoMC with the aim of identifying some feasible strategy.

2.5.6 Updating staff on National Malaria Control Strategy:

The CSP in partnership with DoMC facilitated the training of 20 health workers from the following cadres: PHO's(100%),PHTs (50%) and Laboratory Technicians (50%). These are the staff involved primarily in malaria control in the district. Following the training, the staff developed a district malaria control strategy based on the RBM strategy.

2.5.7 Africa Malaria Day Celebrations

The CSP was part of the steering committee that organized celebration of the Africa Malaria Day held on 25th April 2002 (this was the first observance of the day in the district).

The CSP joined other stakeholders in the district and used the occasion to launch the malaria control initiatives in the district (with an emphasis on the C/HH IMCI approach). The theme of the celebrations for the district was emphasizing "the role of the community and households in RBM initiatives."

Celebrations were marked in one of the primary schools in an area that has poor access to health care. During the celebrations, that were also attended by the DC Teso District, there was HAD activities but with a focus on malaria prevention and treatment.

2.6 Strengthening the capacity of local partners at the district level (health workers) for improved management of district health services in Pneumonia Case Management.

2.6.1 Training health workers on improved Pneumonia Case Management
To achieve this, the CSP in partnership with DCH-MoH and AMKENI Project, has planned to train the health workers using the IMCI strategy. To date 29% of health workers in one facility (6% of total number of facilities) have been trained in SCM. The CSP is also in discussion with MoH on training of CHWs for home case management through the provision of first line antibiotics.

2.6.2 Improved care seeking behavior.

CSP has continued to share messages on care seeking behavior for pneumonia, as well as the management aspect. This has been through community mobilization forums as well as other community activities. This will be strengthened with the involvement of CHWs and other CORPs – within the HH/C IMCI initiatives.

2.7 Strengthening the capacity of local partners at the district level (health workers) for improved management of district health services in Control of Diarrhea Diseases.

2.7.1 Training health workers on improved Management of child with diarrhea:

To achieve this, the CSP in partnership with DCH-MoH and AMKENI Project, has planned to train the health workers using the IMCI strategy. To date 29% of health workers in one facility (6% of total number of facilities) have been trained in SCM. The CHWs and other identified CORPs will be trained in home management of diarrhea as well as making appropriate referral.

2.7.2 Prevention/control of diarrheal diseases:
The CSP has been sharing messages on household practices that promote hygiene as well as prevention of diarrhea. This has been through community mobilization and other activities. This will be strengthened through the proposed health promotion strategy as well as the establishment of community-based structures.

2.8 Strengthening the capacity of local partners at the district level (health workers) for improved management of district health services in increased immunization coverage and Vit A supplementation.

There has been minimal input from the project in this area as the DHMT felt that they needed to concentrate on the GAVI funded activities.

Currently, the Teso CSP and the DHMT Teso are in discussion to outline the strategies for strengthening the immunizations and harmonizing with the other immunization initiatives supported by GAVI.

Meanwhile, the CSP has been involved in sharing messages with the community on immunization with the goal of increasing community demand for immunization services.

The CSP supported the district NID activities. The Measles NID campaign was held 17th June- 23June 2002.The CSP was involved in community mobilization activities, training and provision of logistical support during the campaign. The district achieved a coverage rate of 115% .

2.9 Strengthening the capacity of local partners to implement HH/C IMCI and IMCI:

2.9.1 Improving the skills of health care workers- IMCI Component 1:

Through the partnership support established between WVK Teso CSP, AMKENI Project, DCH-MoH, PHMT Western Province and DHMT, the district has developed a five-year plan (2002-2006) and strategies for implementing the IMCI strategy in the district. According to the plan, the project targets 100% of the health care workers in all the 16 facilities for training in IMCI.

During the year, 33% health workers in only one facility –District Hospital, were trained. There is need to establish system for monitoring the performance of these workers. Likewise, the district needs to identify the level of facilitators to be trained; they will then support and scale up the training of other health workers. Finally, there is need to restrategize the training approach for health workers in order to ensure that health care workers in the peripheral health units also get trained. This is important, as the IMCI strategy is the most cost beneficial (approach) in the peripheral health units because they have very limited or no access to diagnostic facilities. The CSP will support the district in these strategies.

2.9.2 IMCI Component 2- Improving Health Systems

The CSP partnership supported the district in developing a five-year plan 2002-2006 for the implementation of IMCI in the district. This is one of the major achievements in FY1. The districts have been allocated some funding to support this initiative, and the plan is in line with the MoH strategic plan. It is hoped that the district will take the initiative in improving the health system as the plan was based on the available resources. One result of these efforts has been that the MoH has provided a supplementary drug kit to the facility where the 33 % health workers were trained, and there are plans to continue this initiative. The CSP in

partnership with the DHMT will develop a drug availability monitoring system for an effective drug supply and management system for the district.

- Strengthening the district HMIS / HIS.
  The activities for strengthening the HMIS will commence during the first quarter of FY2. The delay has been due to the project HMIS coordinator joined the project during the last quarter of FY1.

2.9.3 Improving House Hold and Community practices

- Improving partnership between health facilities and community:

  The CSP seeks to strengthen this through the selection, training and supervision of health facility committees, VHCs and CHWs as well as other CORPs, to provide a linkage between the health facilities and the communities. The AKHS CHD department provides the technical support for training and supervision based on the "Dispensary Model" and will develop training packages and tools for use in training and supervision of these groups. As part of the process, the CSP in partnership with the DHMT developed the roles and functions, criteria and the selection process of the VHCs and CHWs (see the attachments)
  .
  The VHCs will be selected on sub location basis, for a total of 87 committees.

  Time frame for carrying out the process i.e selection and training:

  Phase 1 (Sep, Oct, Nov '02)
  Phase 2 (Jan, Feb, Mar '03)
  Phase 3 (April, May, Jun '03).

  During the first year, the project achieved 12% selection of VHCs. The training is scheduled to start in November 2002, following the training of facilitators.

  Increase appropriate and accessible care and information from community based providers:

  The CSP has identified the following community based providers to work with.
  - Women groups
  - CHWs and TBAs
  - Shopkeepers
  - Herbalists

The training of women groups has already commenced as part of the ITN marketing strategy. There are a total of 400 registered groups in the district, most of them inactive. The CSP in consultation with district stakeholders plans to train a total of 24 groups, over the period September 2002- June 2003. The goal is to get six women's groups active and participating in CS activities in each division during this period. This number will be revised and increased when the community development motivators are hired.

At the end of FY1, eight groups (33%) of the planned target has been achieved. The CSP is in the process of developing M&E tools to monitor implementation and progress.

Training of the other community based providers has not started yet, as it was felt that the project should establish VHCs and health facility committees first, who will then provide a structural framework for the design and support (of the functioning) of these groups. In addition, the CSP, together with partners, is in the process of adapting training and supervision tools that will be used to support these groups. The training of these groups is scheduled to start during the 2nd quarter FY2.

- Integrated promotion of key family practices critical for child health and nutrition:

  The CSP, in partnership with the DCH, DHMT and other partners have started developing a strategy for achieving this. The strategy is due to be available during the 2nd quarter of FY2. Meanwhile, the CSP has continued to share key family practices messages with the communities during community meetings and other forums.

2.9.4 Support district to develop a health promotion strategy:

Behavior change is one of the major goals of the CSP initiatives. Behavior change plays a critical and central role in contributing to the final goal of improved care seeking, management of the sick child and adapting behavior that will promote health and prevent illness. In order to effectively achieve this, the CSP together with partners has adapted the “health promotion” approach as it addresses the issues of what factors influence behavior and what factors lead to behavior change, under what conditions and what supports behavior change. The health promotion approach also provides the opportunity to examine factors not only in the home environment, but also in the community and wider policy level that need to be addressed in order to support behavior change.

Through developing and adopting this approach in Teso district, the CSP will be able to influence wider policy level especially on CS issues.

The "Health Promotion" strategy encompasses health education, social mobilization, IEC development/production, social marketing and advocacy as well as identifying structures and appropriate avenues for channeling the information. The project did an initial needs assessment and identified gaps in health promotion in the district, existing opportunities for scaling up health promotion activities and the key actors and potential stakeholders for their involvement/participation in development and implementation of Health Promotion. IEC materials were also pretested. The health promotion strategy will be available during the 1st quarter of FY2. Meanwhile, following the pre-testing of some of the IEC, the CSP in partnership with DoMC has begun reproducing the materials.

3.0 Management Systems

3.1 Financial Management system

The project uses the WV "SUN" accounting system. Project funds are disbursed based on the project DIP and discussed with the project manager and other partners to ensure they meet technical relevance and rationale.

The project accountant and project manager have been trained in " USAID Financial rules and regulations" conducted by the Association of PVO Financial Managers. There are plans to train other project staff and partners on financial management. The project is due for auditing during the first quarter of FY2.

The project accountant and project managers prepare monthly financial reports and narrative reports indicating financial expenditures in relation to activities.

3.2 Human Resources

The project manager is responsible for giving technical guidance and supervision to the project staff. The staff have job descriptions to facilitate their understanding of roles. The staff meets regularly on weekly basis to analyze and review project activities. The office administrator and HIS coordinator came on board during the last quarter FY1. This has greatly eased the coordination and logistical difficulties experienced by the project. The recruitment of motivators which is expected to be undertaken

in quarter 1 FY2 will facilitate community mobilization and training for child survival initiatives.

At the national level, the Project Manager is supported by the WV National Health Coordinator, The HIV coordinator and Special program Officer. There has been no staff turn over in the field office.

3.3 Communication System

Communication at the project level is through weekly staff planning and review meetings as well quarterly planning meetings. Communication with the national level is through the monthly and quarterly reports as well as weekly telephone communication with the program officer and National Health Coordinator.

Establishment of a telecommunication system at the project level has been delayed due to a number of factors. One of them is the unavailability of office space at the District Hospital as had been planned.
Disagreement arose regarding procedures for renovating the building. This was the main obstacle. However, following discussions and consultations between the partners, the issue has been resolved and the office should be ready for occupation during the first quarter of FY2. The project will then install the telecommunication system that will facilitate the use of electronic mailing system, fax and telephone.

Based on the partnership between WV and Afri-Afya (communication network), the CSP has been included as one of the eight field sites in the country and will have a world space receiver communication system. This will facilitate communication between the CSP and other sites, but more importantly between the community and the other communities linked up. The CSP shall make use of this system for wider use at the district level, to include all stakeholders involved in CS and other development initiatives in the district.

3.2 Relationship with local partners

The local partners at district level include the DHMT and other district level departments. Due to high turn over of the position of the DMOH, the project has been unable to establish a meaningful relationship with the DHMT, to the point that the project and DHMT failed to have joint plans on certain activities including supervision, immunization and Quality Improvement.

Though there was an agreed upon framework for collaboration in the form of signed minutes between the two partners, this seemed or was disregarded with the change of DMOH. Where the partnership seemed more effective at district level (demonstrated in the level of achievement

of activities), the project had to involve national level and provincial level staff to influence the DHMT. However, the CSP and DHMT have recently held a planning meeting and have agreed to work jointly.
The partnership with other district departments seemed to work relatively well.

3.3 PVO coordination/collaboration with other PVOs in the Country.

The PVO established and maintained effective collaborative relationships with other PVOs that have supported the CS initiatives. Perhaps this is one of the strongest structures supporting the CSP. The CSP has established partnership with AMKENI and DCH-MoH in the training of health workers on IMCI. The CSP also has a very supportive partnership with AKHS-CHD, AMREF-BDMI, Care Siaya CS project, PLAN CS Kwale and DoMC. These partners play an advisory role to the CSP, and some of them give direct technical input.

Partnerships are also being established with FHI and JHPIEGO.
The CSP maintains regular communication with the USAID local mission PHN.

4.0 TECHNICAL ASSISTANCE REQUIRED

Based on the project activities, challenges and achievements, the project requires technical support in some key areas:

- Project M&E system design especially for monitoring community based interventions and initiatives.
- Development of communication strategy
- PLA/PRA techniques and skills
- Advocacy skills
- Formative Research Skills

5.0 ATTACHMENTS

Attachment 1……..Project 5 year plan
Attachment 2……..Five year Training Plan
Attachment 3……..Overall M&E plan
Attachment 4……..Revised budget
Attachment 5……..Project security plan
Attachment 6……..Annual Plan FY2
Attachment 7……..Functions of, Criteria and Process of Selection of VHCs and CHWs.

ATTACHMENT 7
WORLD VISION TESO CSP /MOH TESO DISTRICT
CRITERIA FOR SELECTION VHCs & CHWs 14TH AUGUST 2002

SELECTION CRITERIA FOR CHWS

- Must be resident in the area
- Must be selected by the community
- Must have demonstrated leadership qualities
- Must be literate
- Must have knowledge of the local language
- Must be willing to serve the community on voluntary basis
- Must be community based
- Not planning to leave the community
- Must be at least 18 years old
- Must be respected member of the community
- Must be ready to learn
- Must be a role model

(iv) CRITERIA FOR SELECTING VHC MEMBERS

- As in selection of CHW above, with the following additions
- Must be willing to meet regularly
- Should be available at least twice a week
- Must not have political bias in dealing with the community members
- Must be willing to represent community interest.

(V) PROCESS OF ESTABLISHING VHCs & CHWs

- VHCs will be formed as per location. This will give a total of 87 VHCs.
- Priority areas for establishing the VHCs and CHWs first-
  - Inaccessible areas
  - Distance from nearest health facility
  - Areas with low immunization coverage
  - Areas with high mortality & morbidity of priority diseases.

- **Proposed Steps for establishing VHCs**
  - Mobilize communities and facilitate selection of VHCs first
  - Train the VHCs
  - Mobilization exercise to be conducted by MOH staff, Ministry of Culture and Social Services, Provincial Administration and WVK Teso CSP staff.
  - Training from location to location.

⇨ ***Time frame for VHCs Selection and training***

- Two weeks for locational mobilization
- One week for selection
- Two weeks for planning and actual training
- One week for selection of CHWs
- Two weeks for training of CHWs ***(Phase 1)***

⇨ Phase 1 expected to take 3 months for completion.
Each phase will take 3 months, as follows:

Phase 1
September, October and November 2002.

Phase 2
January, February, March 2003

Phase 3
April, May June 2003.

ATTACHMENT 6 - TESO CSP. FY 2 (OCT 2002-SEP 2003) ANNUAL WORK PLAN

Objective & Activities	Agency/ Persons responsi-ble	OCT '02				NOV '02				DEC '02				JAN '03				FEB'03				MAR '03				APR'03				MAY'02				JUN'03				JUL'03				AUG'03				SEP'03			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Support the district in HMIS strengthening	WVK, AKHS, MoH																																															
(i) Assess District HMIS																																																
(ii) Design HMIS model including community HMIS model																																																
(iii)Purchase computer and printer for district																																															
(iv)Computerize HMIS for MOH Teso																																																
(v)Train DHMT on the computerized HMIS																																																
(vi) Train DHRIO on computer skills																																																
(vii) Conduct training on HMIS implementation at community level (VHCs, Health facility committees)																																																
(viii) Facilitate the establishment of support supervision systems for HMIS																																																
(ix) Conduct support supervision																																																

Objective & Activities	Agency/ Persons responsi-ble	OCT '02				NOV '02				DEC '02				JAN '03				FEB'03				MAR '03				APR'03				MAY'02				JUN'03				JUL'03				AUG'03				SEP'03			
2. Strengthening the capacity of local partners to implement HH/C IMCI	WVK DMOH Teso, MoH																																														
(i)Train health workers on IMCI	WVK, Partners																																														
(ii)Conduct support supervision and Quality Improvement (QI) strategies for Child Health(health workers &CORPS)	WVK, Partners																																													
(iii) Community mobilization to establish community level organizations/structures for community HH/C IMCI (VHC, CHWs)	WVK, MoH, Other stakeholders																																													
(iv) Training of facilitators(WVK, MOH) for VHC training	MOH, WVK																																													
(v) Training of VHCs	MOH, WVK and partners																																													
(vi) Training of facilitators on health promotion (WVK & MOH)	AMREF, AKHS																																													

Objective & Activities	Agency/ Persons responsi-ble	OCT '02				NOV '02				DEC '02				JAN '03				FEB'03				MAR '03				APR'03				MAY'02				JUN'03				JUL'03				AUG'03				SEP'03			
(vii) Develop/Adapt curriculum/training package for training CHWs on HH/C IMCI	WVK, MoH, Partners																																															
(viii)Training of CHWs and other CORPs	WVK, MOH,																																															
(ix) Conduct training for health facilities committees	WVK, MOH																																															
(x) Follow up training for DHMB, DHMT	WVK																																															
(xi) Training of women groups	WVK, MOH																																															
(xii) PRA/PLA training facilitation skills (WVK,MOH)	WVK, partners																																															
(xiii) PLA/PRA with communities	WVK MOH																																															
3. Develop and implement Behavior Change and Communication Strategy for Child Survival Initiatives																																															
(i) Identify mechanisms/means to build the capacity within the district for health promotion	WVK, MoH																																															

Objective & Activities	Agency/ Persons responsi-ble	OCT '02				NOV '02				DEC '02				JAN '03				FEB'03				MAR '03				APR'03				MAY'02				JUN'03				JUL'03				AUG'03				SEP'03			
(i)Reproduce/Develop and disseminate BCC IEC materials	WVK, MoH																																														
4. HIV/AIDS/STI Control																																															
i) Support district to strengthen HIV/AIDS/STI surveillance	WVK, MOH																																														
(ii) Support district to establish 2 VCT sites	WVK, FHI																																														
(iii) Strengthen Community Based Responses to HIV/AIDS	All																																														
(iv) Train young people on life skills for HIV/AUDS prevention	All																																														
(v) Train women/partners on safe sex practice including negotiation skills	All																																														
5. Immunization and Vit A supplementation																																															
(i) Refresher course training for health workers on EPI	WVK, KEPI, MoH																																														
(ii) Establish tracking system for monitoring “drop-out” and “missed opportunity	DHMT																																														

Objective & Activities	Agency/ Persons responsi-ble	OCT '02				NOV '02				DEC '02				JAN '03				FEB'03				MAR '03				APR'03				MAY'02				JUN'03				JUL'03				AUG'03				SEP'03			
(iii)Participate in NIDs and surveillance	WVK																																														
(iv) Support immunization outreach activities including Vitamin A supplementation	WVK, Health Facility Comm.																																														
6. Malaria Control																																															
(i)Training of health workers and implementation of IPT strategy at district level	WVK, JHPIEGO																																														
(ii)Training of health workers for timely malaria treatment for children (IMCI)	WVK, AMKENI, MOH																																														
(iii)Training of CORPs focussing on key family practices for malaria management and prevention	WVK, MoH																																														
(iv) PLA with families and communities on malaria prevention and management practices	All																																														
(v) Identify supplier of ITNs, train community groups and strengthen social marketing skills and strategies for ITN promotion/ marketing	WVK, PSI																																														

Objective & Activities	Agency/ Persons responsi-ble	OCT '02				NOV '02				DEC '02				JAN '03				FEB'03				MAR '03				APR'03				MAY'02				JUN'03				JUL'03				AUG'03				SEP'03			
(vi) Work with CORPs for follow up on ITNs (use, re treatment, care)	WVK, MoH																																													
7. Others																																														
(i) Office renovation	WVK																																													
(ii) Other WVK DDC activities	WVK, Partners																																													
(iii) PHMT activities, Consultations, Steering committees	WVK																																													

ATTACHMENT 5
WORLD VISION TESO CSP /MOH TESO DISTRICT
PROJECT SECURITY PLAN

- The CSP staff have been provided with Cellular phone facilities to facilitate communication in the field.
- The CSP project office maintains regular communication with the Provincial/District administration and will be advised/informed in case of any security concerns.
- The CSP office maintains daily telephone communication with the WV National Office and weekly with the WV zonal office.
- The CSP Project Manager maintains daily communication with all project staff.
- In case of any security concern, the Project Manager shall organize and facilitate the movement of staff from the field in collaboration with the Provincial Administration, WV Zonal Office and WV National office.

ATTACHMENT 3: WORLD VISION TESO CSP /MOH TESO DISTRICT – OVERALL M&E PLAN

SEP 2002.

Expanded Program On Immunization			
Objectives By the end of 5 years:	**Measurement Method & Frequency**	**Major Inputs/ Key Activities**	**Who is Responsible**
70% children aged 12-23 months who received a Vit. A dose in the last 6 months. (Baseline 43.3%)	• Baseline, mid-term, final KPC • MOH data	• PLA with mothers/fathers/caregivers and communities on benefits of immunization and vit. A for children and lactating women • Train CHWs on immunizations, vit. A and VHCs on community mobilization • Develop community and health facility tracking system for "drop-outs" and " missed opportunities	• MOH-Teso (DPHN, DPHO) • WVK (DFC, Motivators) • KEPI • CORPs • Other district stakeholders
90% children 0-23 months who have an immunization card (Baseline 64.5%)	• Baseline, mid-term, final KPC • MOH data	• As above • Also ensure consistently availability of cards.	• As above
100% children 12-23 months who received DPT 1 (Baseline 97.0%)	• Baseline, mid-term, final KPC • MOH data	• As above • Improve outreach services through effective management of resources and community generated cost-recovery system_	• As above • VHCs and Health Facility Committees
90% children 12-23 months who received measles vaccine (Baseline 70.1%)	• Baseline, mid-term, final KPC • MOH data	• As above • Improve outreach services through effective management of resources and community generated cost-recovery system_	• As above • VHCs and Health Facility Committees
Reduction in drop-outs between DPT 1 and DPT 3 to below 5 % (Baseline 12.3%)	• Baseline, mid-term, final KPC • MOH data	• As above • Improve outreach services through effective management of resources and community generated cost-recovery system_	• As above • VHCs and Health Facility Committees
90% Full immunization coverage –children 12-23 months who received BCG, DPT/Hep B/HiB 3, OPV3 and measles vaccines. (Baseline 68.7%)	• Baseline, mid-term, final KPC • MOH data	• As above • Improve outreach services through effective management of resources and community generated cost-recovery system_	• As above • VHCs and Health Facility Committees
80% mothers with child 0-23 months who received at least 2 TT before birth of youngest child.	• Baseline, mid-term, final KPC • MOH data	• As above • Improve outreach services through effective management of resources and community generated cost-recovery system • PLA with mothers/families and communities on benefits of TT immunization for WRA	• As above

Control of Diarrheal Diseases			
Objectives By the end of five years:	**Measurement Method & Frequency**	**Major Inputs/ Key Activities**	**Who is Responsible**
30% infants aged 0-5m exclusively breast fed (Baseline 10.2%)	• Baseline, mid-term, final KPC • MOH data	• PLA with mothers/fathers/caregivers and communities on benefits of exclusive breast feeding practices • Train CHWs, other resource persons and mothers/families on correct breast feeding practices/techniques • Identify “Positive deviants” to act as change agents for motivating community to adapt appropriate behavior. • Supervision and monitoring.	• MOH-Teso • WVK • CORPs
20% infants aged 6-9 m receiving breast milk and complementary foods within last 24 hours (Baseline 1.6%)	• Baseline, mid-term, final KPC. • MOH data	• PLA /Health promotion with mothers/fathers/caregivers and communities on benefits of correct infant feeding practices • Train CHWs, other resource persons and mothers/families on correct infant feeding practices/techniques. • Identify “Positive deviants” to act as change agents for motivating community to adapt appropriate behavior. • Supervision and monitoring.	• MOH-Teso • WVK • CORPs
20% mothers/caregivers of children aged 0-23m who wash their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated. (Baseline 1.7%)	• Baseline, mid-term, final KPC • MOH data	• PLA /Health Promotion with mothers/fathers/caregivers and communities on benefits of hand washing practices • Identify “Positive deviants” to act as change agents for motivating community to adapt appropriate behavior. • Supervision and monitoring.	• MOH-Teso • WVK • CORPs
40% Children aged 0-23mwho received increased fluids and continued feeding during an illness in the past two weeks (Baseline 2.8%)	• KPC- Baseline, mid-term and final evaluation. • MOH data	• PLA /Health Promotion with mothers/fathers/caregivers and communities on appropriate home care and treatment for children with diarrhea. • PLA/Health promotion with mothers/fathers/caregivers/families and communities on appropriate recognition of “danger sign” for appropriate care seeking. • Training of health workers on correct classification and management of child with diarrhea. • Training and supervision of CHWs, VHCs, and other CORPS and Community groups on care, management and referral of sick child.	• MOH-Teso • WVK • CORPs

Objectives By the end of five years:	**Measurement Method & Frequency**	**Major Inputs/ Key Activities**	**Who is Responsible**
50% of children aged 0-23m who received increased fluids during an illness in the past two weeks (Baseline 7.6%)	• KPC- Baseline, mid-term and final evaluation. • MOH data	• PLA /Health Promotion with mothers/fathers/caregivers and communities on appropriate home care and treatment for children with diarrhea. • PLA/Health promotion with mothers/fathers/caregivers/families and communities on appropriate recognition of “danger sign” for appropriate care seeking. • Training of health workers on correct classification and management of child with diarrhea. • Training and supervision of CHWs, VHCs, and other CORPS and Community groups on care, management and referral of sick child.	• MOH-Teso • WVK • CORPs
50% of children aged 0-23m who received increased food intake during an illness in the past two weeks (Baseline 17.1%)	• KPC- Baseline, mid-term and final evaluation. • MOH data	• PLA /Health Promotion with mothers/fathers/caregivers and communities on appropriate home care and treatment for children with diarrhea. • PLA/Health promotion with mothers/fathers/caregivers/families and communities on appropriate recognition of child illness with” danger sign” for appropriate care seeking outside the home. • Training of health workers on correct classification and management of child with diarrhea.	• MOH-Teso • WVK • CORPs
70% mothers of children aged 0-23m who indicate at least two known “danger signs” of childhood illness that indicate need for treatment	• KPC- Baseline, mid-term and final evaluation	• PLA/Health promotion with mothers/fathers/caregivers/families and communities on appropriate recognition of child illness with “danger sign” for appropriate care seeking outside the home. • PLA /Health Promotion with mothers/fathers/caregivers and communities on appropriate home care and treatment for sick child-to follow health workers advice about treatment, follow up and referral. • Training of health workers on correct classification and management of child with diarrhea. • Training and supervision of CHWs, VHCs, and other CORPS and Community groups on care, management and referral of sick child.	• MOH-Teso • WVK • CORPs

Pneumonia Control			
Objectives By the end of five years:	**Measurement Method & Frequency**	**Major Inputs/ Key Activities**	**Who is Responsible**
80% of mothers of children aged 0-23m who identify "fast/difficult" breathing as danger sign that indicate need for treatment of child outside home. (Baseline 21.1%)	• KPC- Baseline, mid-term, and final evaluation	• PLA/Health promotion with mothers/fathers/caregivers/families and communities on appropriate recognition of child illness with "danger sign" for appropriate care seeking outside the home. • PLA /Health Promotion with mothers/fathers/caregivers and communities on appropriate home care and treatment for sick child- to follow health workers advice about treatment, follow up and referral. • Training of health workers on correct classification and management of child with Pneumonia. • Training and supervision of CHWs, VHCs, and other CORPS and Community groups on care, management and referral of sick child.	• MOH-Teso • WVK • CORPs
70% of children aged 0-23m with history of "cough/difficulty" breathing who were taken for treatment within 48 hours of onset (Baseline 32.1%)	• KPC- Baseline, mid-term, and final evaluation	• PLA/Health promotion with mothers/fathers/caregivers/families and communities on appropriate recognition of child illness with "danger sign" for appropriate care seeking outside the home. • PLA /Health Promotion with mothers/fathers/caregivers and communities on appropriate home care and treatment for sick child- to follow health workers advice about treatment, follow up and referral. • Ensure availability of drugs at health facilities/ other appropriate source. • Training of health workers on correct classification and management of child with Pneumonia. • Training and supervision of CHWs, VHCs, and other CORPS and Community groups on care, management and referral of sick child.	• MOH-Teso • WVK • CORPs
70% of children aged 0-23m with history of "cough/difficult" breathing who were taken to a health facility or received antibiotic from an alternative source within 48 hours of onset. (Baseline 45.5%)	• KPC- Baseline, mid-term, and final evaluation	• PLA/Health promotion with mothers/fathers/caregivers/families and communities on appropriate recognition of child illness with "danger sign" for appropriate care seeking outside the home. • PLA /Health Promotion with mothers/fathers/caregivers and communities on appropriate home care and treatment for sick child- to follow health workers advice about treatment, follow up and referral. • Ensure availability of drugs at health facilities/ other appropriate source. • Training and supervision of Health workers, CHWs, VHC and other Community groups on care, management and referral of sick child.	• MOH-Teso • WVK • CORPs

Malaria Management			
Objectives By the end of five years:	**Measurement Method & Frequency**	**Major Inputs/ Key Activities**	**Who is Responsible**
50% children aged 0-23m with febrile episode that ended in the last two weeks who were treated with an effective (recommended) anti malarial within 48 hours of onset of fever (Baseline 19.5%)	• KPC Survey- Baseline, mid-term and final evaluation. • Clinic interviews (during service delivery)	• Train and supervise CHWs and VHCs in malaria treatment and control • PLA with mothers/caregivers and families on danger signs of malaria, importance of early diagnosis, prompt treatment, completion of treatment • Develop and distribute guides for CHWs • Ensure adequate supply of SP is available at community level	• MOH • WVK
80% children aged 0-23m with febrile episode that ended during the last two weeks who were taken to health facility within 48 hours of onset of fever (Baseline 44.4%)	• KPC Survey- Baseline, mid-term and final evaluation.	• Train and supervise health facility staff on malaria case management • PLA with mothers/caregivers and families on danger signs of malaria, importance of early diagnosis, prompt treatment, completion of treatment • Develop and distribute guides for CHWs • Ensure adequate supply of SP is available at community level •	• MOH-DCH • MOH-Teso • WVK
40%mothers who took anti-malaria prophylaxis during last pregnancy (IPT) (Baseline-not assessed)	• KPC- mid-term, final evaluation. • Clinic records (antenatal) and mothers interview.	• Train and supervise health workers on IPT • Train and supervise CHWs and VHCs in malaria treatment and control • PLA with mothers and families on importance of prophylaxis in pregnancy • Develop and distribute guidelines for CHWs • Distribute IPT guidelines on IPT • Ensure adequate supply of SP is available at community level	• MOH-DoMC • MOH-Teso • WVK
30% children 0-23 months who slept under insecticide impregnated bed-net the previous night (Baseline 6.9%)	• KPC- mid-term, final evaluation.	• PLA with mothers/caregivers, fathers families and communities on benefits of ITN • Train and supervise women's groups and marketing of ITN • Ensure that ITN are available and affordable and are retreated	• MOH- DoMC • MOH-Teso • WVK • Other partners

HIV/AIDS			
Objectives By the end of the five years:	**Measurement Method & Frequency**	**Major Inputs/ Key Activities**	**Who is Responsible**
70% mothers of children aged 0-23m who cite at least two ways of HIV prevention (Baseline 41.5%)	KPC- Baseline, mid-term and final evaluation.	• PLA with mothers, fathers, families and community on HIV/AIDS/STI transmission and methods of prevention. • Develop and implement BCC •	• MOH- NASCOP • MOH-Teso • DACC • WVK
20% mothers of children aged 0-23 m who report negotiating for safe sex practices. (Baseline-not established)	KPC- mid-term and final evaluation	• PLA with WRA and men on HIV/AIDS prevention skills • PLA with youth in and out of school on HIV/AIDS/STI prevention skills • PLA with "High-risk" groups (e.g., adolescents, commercial sex workers, street children, truckers) • Train counselors and Establish VCT centers.	• DACC • WVK • Partners
80% mothers of children aged 0-23m who indicate willingness to care for HIV/AIDS+ve relative. (Baseline 65.7%)	KPC- mid-term and final evaluation	• PLA with families, communities and leaders (including religious) to identify community based strategies for HIV/AIDS prevention and control	• DACC • WVK • Partners
80% mothers of children aged 0-23m who indicate willingness to allow HIV/AIDS+ve teacher to continue teaching. (Baseline 49.1%)	KPC- mid-term and final evaluation	As above	• DACC • WVK • Partners
80% mothers of children aged 0-23m who indicate willingness to allow HIV/AIDS+ve child to play with own child. (Baseline 47.1%)	KPC- mid-term and final evaluation	As above	• DACC • WVK • Partners

Capacity Building			
Objectives By the end of the five	**Measurement Method & Frequency**	**Major Inputs/ Key Activities**	**Who is Responsible**
100%Health workers in the health facilities in the district trained in IMCI and practicing IMCI in the last three months.	• HFA- mid-term, final evaluation. • Quarterly Training records (Project & MOH)-	• Training and supervision of health workers on IMCI • Avail IMCI guidelines	• MOH-DCH • MOH-Teso • WVK
70% sub locations with selected and trained and functioning VHC.	• Records (VHC, MOH) • Quarterly Training records (Project & MOH) • Final evaluation-KPC	• Develop criteria for selection of VHC • Train and supervise VHC • Monitor for quality performance	• MOH-Teso • Partners-AKHS • WVK
70% sub locations with trained and functioning VHC and at least 1 CHW per 40 households (trained and visiting each household at least Monthly).	• Quarterly Training records (Project & MOH) • Records (VHC, MOH) • Final evaluation-KPC	• Develop criteria for selection of CHWs • Train and supervise CHWs • Monitor for quality performance	• MOH-Teso • WVK
50% sub locations with trained and functioning VHC and at least 1 CHW per 40 households (trained and visiting each household at least monthly) in place, have a community development action plan in place.	• Yearly review of sub locations through site visits • Supervision Records (VHC, MOH) • Final evaluation-KPC	• Assist with development, implementation and evaluation of community action plan	• MOH-Teso • WVK

Sustainability			
Objectives By the end of the five years:	**Measurement Method & Frequency**	**Major Inputs/ Key Activities**	**Who is Responsible**
70% sub locations with selected and trained and functioning VHC.	• Records (VHC, MOH) • Quarterly Training records (Project & MOH) • Final evaluation-KPC	• Develop criteria for selection of VHC • Train and supervise VHC • Monitor for quality performance	• MOH-Teso • AKHS • WVK
70% sub locations with functioning VHC and at least 1 CHW per 40 households (visiting each household at least monthly) trained.	• Quarterly Training records (Project & MOH) • Records (VHC, MOH) • Final evaluation-KPC	• Develop criteria for selection of CHWs • Train and supervise CHWs • Monitor for quality performance	• MOH-Teso • AKHS • WVK
50% sub locations with trained and functioning VHC and at least 1 CHW per 40 households (trained and visiting each household at least monthly) in place, have a community development action plan in place.	• Yearly review of sublocations through site visits • Supervision Records (VHC, MOH) • Final evaluation-KPC	• Assist with development, implementation and evaluation of community action plan	• MOH-Teso • WVK
100% Health facilities have QI mentor in place.	• Yearly review of health facilities • Monthly support visits	• Train at least one staff from each health facility to take on the role of QI mentor. • Ensure that monthly support visits take place and quality standards are met.	• MOH-Teso • WVK

ATTACHMENT 2: FIVE YEAR TRAINING PLAN TESO CSP 2001-2006

TOPIC OF TRAINING	PARTICIPANTS	Trainer/Facilitator	YEAR 1 Oct 01 /Sep 02				YEAR 2 Oct 02 /Sep 03				YEAR 3 Oct 03/ Sep 04				YEAR 4 Oct 04 /Sep 05				YEAR 5 Oct 05 / Sep 06			
			1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Management of Health Services • Health Sector Reforms • Roles and functions of DHMTs /DHMBs • District Resource Mobilization • Transformational development	• DHMT members • DHMB members • Hospital Management Board members	• MOH-Division of Health Care Financing • AKHS • WVK			X	X	X	X	X	X		X		X		X		X		X		
Managing Community Health Services • Health education • Governance issues and skills • Financial management/HMIS • Action planning • Health action • Communication skills • Transformational development	Members of the following committees: • Health Center committees • Dispensary Health Committees • Village Health committees	• AKHS • MOH • Ministry of Culture & Social services • WVK				X	X	X	X	X			X		X		X		X		X	
Community Child Survival Initiatives • PLA/PRA, Community development • Health Promotion • Communicating Behavior Change messages • Key family practices (C/HH IMCI)- focussing on Control of Diarrheal Disease, Control of Malaria, Immunization, Vitamin A supplementation, Improved Pneumonia Case Management, and other 16 key family practices • Transformational development	• Project Staff • MOH staff • CHWs • Other CORPs	• WVK • MOH-DCH • MOH-Teso • MOH-DoMC/DHEO • Other partners				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
• Community Mobilization & Facilitation Skills / Purpose & Formation of Health Committees (TOT)	• Project staff • MOH staff • District stakeholders • CORPs	• AKHS • WVK • Other partners				X	X															

TOPIC OF TRAINING	PARTICIPANTS	Trainer/Facilitator	YEAR 1 Oct 01 /Sep 02				YEAR 2 Oct 02 /Sep 03				YEAR 3 Oct 03/ Sep 04				YEAR 4 Oct 04 /Sep 05				YEAR 5 Oct 05 / Sep 06			
			1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Health Information System • Proper collection and reporting of data • Use and analysis of data at the level it is collected for the purpose of decision making and targeting of interventions	• DHMT • Facility Health Workers • CHWs(Other CORPs) • VHCs/ Health Facility committees	• AKHS • WVK • Partners				X	X	X	X	X			X				X				X	
Supervision Skills and Plans of Action • How to carry out a supervision visit • How to make a monthly action plan • Team leading skills • How to make a job description	• DHMT • Facility Health workers • Project staff	• AKHS • MOH-DCH • WVK • Partners				X	X	X			X				X				X			
Integrated Management of Child hood illness (IMCI) • Assessment • Classification • Identify treatment • Counsel mother • Refer appropriately • Follow up	• DHMT • Facility Health workers • Project staff	• MOH-DCH			X	X	X	X	X	X	X						X			X		
Community Development • Record keeping/HIS (basic) • Basic business management • Financial management • Resource mobilization • Health promotion to include The 16 key family practices for improved child health.	• Women groups • Other groups	• MOH-Teso • Ministry of Culture/Social Services • WVK • Partners (AMREF)				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

TOPIC OF TRAINING	PARTICIPANTS	Trainer/Facilitator	YEAR 1 Oct 01 /Sep 02				YEAR 2 Oct 02 /Sep 03				YEAR 3 Oct 03/ Sep 04				YEAR 4 Oct 04 /Sep 05				YEAR 5 Oct 05 / Sep 06			
			1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
HIV/AIDS/STI Surveillance • Epidemiological skills in HIV/AIDS surveillance • Role of counselling and testing in surveillance • Sentinel Surveillance	• DASCO (DPHN) • STI Coordinator • NO-MCH Clinic • D/Lab Technologist • DHRIO	• NASCOP			X		X					X					X					
Voluntary Counseling and Testing (VCT) • Guidelines for and skills for HIV related counseling • Staffing and management of VCT • Human rights and VCT • Quality assurance for VCT	• Project staff • MOH Staff • Others	• Association of Professional Counselors • WVK				X	X	X			X				X				X			
Malaria Control • Malaria epidemiology • Surveillance • Malaria control strategies • Malaria treatment • Involving communities and other stakeholders in malaria prevention and treatment.	• PHOs • PHTs • Lab technologists • Community Development Assistants.	• DoMC • WVK • Other partners (PSI)			X	X				X			X					X				
Immunization • Cold Chain system and management of vaccines • Social mobilization in immunization program • Planning and implementing M&E for immunization activities • Disease surveillance	• MOH-Teso (DPHN, DPO, DHRIO). • Health workers • Health Centre committees, VHCs, CORPs • Project staff	• MOH-KEPI • MOH-DHMT • WVK • Other partners					X		X			X					X			X		

ATTACHMENT 1: PROJECT 5 YEAR PLAN TESO CSP 2001-2006

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02				YEAR 2 Oct 02/ Sep 03				YEAR 3 Oct 03/ Sep 04				YEAR 4 Oct 04/ Sep 05				YEAR 5 Oct 05/ Sep 06			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
ESTABLISH PROJECT OPERATIONAL STRUCTURES																					
Staff selection and recruitment	WVK																				
Establish office and operational support systems	WVK																				
PROCUREMENT OF SUPPLIES																					
Office Supplies	WVK																				
Equipment	WVK																				
Vehicles and motorcycles	WVK																				
ESTABLISH RELATIONSHIP WITH PARTNERS																					
Sign MOU with MOH at district and national levels	WVK,MOH																				
Sign MOU with Community Based Groups/structures	WVK, Community Based groups																				
Sign MOU with other partner implementing agencies (PVOs)	WVK, Partners																				
Monthly coordination meetings with MOH and other partners at district level for review of activities and planning.	WVK, MOH, Partners																				
Quarterly steering committee meetings at district level and national (advisory) level	WVK, MOH, Partners																				
PLA with communities	WVK, MOH,																				
BASELINE ASSESSMENTS																					
KPC survey design and preparation																					
KPC data collection and analysis	WVK, Partners, Consultants																				

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02	YEAR 2 Oct 02/ Sep 03	YEAR 3 Oct 03/ Sep 04	YEAR 4 Oct 04/ Sep 05	YEAR 5 Oct 05/ Sep 06
FGD data collection and analysis	WVK, Partners					
HFA data collection and analysis	WVK, Partners					
DHMT appraisal	WVK, Partners					
Appraisal of health Committees and Health Boards	WVK, Partners					
Training appraisal (Health workers and CORPs)	WVK, Partners					
DIP preparation	WVK. Partners					
DIP workshop	WVK, Partners					
MONITORING AND EVALUATION						
DIP Report Preparation	WVK, Partners					
HMIS design and implementation	WVK, MOH-Teso, AKHS					
Annual Review and Report Preparation	WVK					
Monthly Report Reviews with local partners	WVK, Partners					
Draw up annual work plan	WVK,MOH-Teso, Partners					
KPC Survey	WVK, Partners					

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02	YEAR 2 Oct 02/ Sep 03	YEAR 3 Oct 03/ Sep 04	YEAR 4 Oct 04/ Sep 05	YEAR 5 Oct 05/ Sep 06
Focus group discussions / key informant interviews	WVK, Partners					
Health Facility assessment interviews including client satisfaction	WVK, Partners					
Mid term evaluation	WVK, Partners					
Final evaluation	WVK, Partners					
Monthly supervision with MOH to motivate community providers	WVK, MOH					
TRAINING -SUMMARY						
Training of health teams and Boards (DHMT, DHMB, Health Facility Committees) (Including follow up)	AKHS, MOH-Teso, WVK					
Training of project staff and district stake holders on malaria prevention, management and control.	MOH-DoMC, WVK, Partners					
HIV/AIDS STI Surveillance training	NASCOP, WVK					
VCT Counselor Training	MOH, Teso, DACC, WVK, Ass. Professional Counselors(K), Partners					
TOT	MOH-TesoAKHS, WVK					
Training of women groups, and other organized groups(and follow up training)	MOH-Teso, WVK, Partners					
Training of VHCs, CORPs (and follow up training)	MOH-Teso, AKHS, WVK., Partners					

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02				YEAR 2 Oct 02/ Sep 03				YEAR 3 Oct 03/ Sep 04				YEAR 4 Oct 04/ Sep 05				YEAR 5 Oct 05/ Sep 06			
TOT for Behavior Change Communication	MOH-Teso, WVK, Partners																				
Training /Refresher course for health workers on EPI	MOH-Teso, KEPI, WVK, Partners																				
INTERVENTIONS																					
1. INTERGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI): Support the District to implement the following components:																					
a) Component # 1: Improving the skills of Health Workers																					
Establish network and support for IMCI at National and Provincial levels	MOH- DCH, PMO Western Province, AMKENI, WVK																				
Conduct "Orientation and planning workshop for IMCI" to assess and determine district's needs for IMCI	MOH-DCH, PMO Western Province, WVK, AMKENI																				
Conduct Case Management Training for key DHMT members	DCH, PMO-Western Province, WVK, AMKENI.																				
Conduct Facilitation Skills for key DHMT members	DCH, PMO-Western Province, WVK, AMKENI.																				
Conduct Case Management Training for 1st level health workers in the district	DCH, PMO-Western Province, DHMT-Teso, WVK, AMKENI																				
Conduct Support Supervision skills Training and follow up skills Training for DHMT and Trained health workers	MOH- Teso, PMO-Western Province, DCH, WVK																				
Conduct support supervision and Quality Improvement for Child Health (health workers, CORPs)	MOH-Teso, PMO-Western Province, WVK, (? Engender Health)																				
b) Component # 2: Improving Health Systems ***Teso CSP will support the district in 2 main areas*** ***1bi) IMCI Planning and Management*** ***1bii)Strengthening HMIS***																					
bi)IMCI Planning and Management																					
Participate and support the district to conduct IMCI Coordination activities	DHMT-Teso, WVK, Other District stakeholders																				

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02	YEAR 2 Oct 02/ Sep 03	YEAR 3 Oct 03/ Sep 04	YEAR 4 Oct 04/ Sep 05	YEAR 5 Oct 05/ Sep 06
bii)Strengthening HMIS						
Assess district HMIS	MOH-Teso, AGKHS, WVK					
Design HMIS model including Community HMIS model	MOH-Teso, AKHS, WVK					
Computerize HMIS for MOH District level HMIS	AKHS, WVK, MOH- Teso District					
Train the Teso Health Facility staff on data collection using Ministry of Health HMIS Forms.	AKHS, PMO Western Province, WVK					
Train DHMT on the computerized HMIS.	AKHS, WVK					
Conduct training on HMIS implementation at community level.	DHMT-Teso, AGKHS, WVK					
Facilitate the establishment of support supervision systems	DHMT-Teso, WVK, AKHS					
Conduct support supervision	DHMT-Teso, WVK					
c. Component # 3: Improving Household and Community Practices						
Establish district Community/Household IMCI coordination framework	MOH- Teso, WVK, District stakeholders					
Conduct District Community/Household IMCI sessions(See section under interventions)						
Community mobilization to establish community level organizations/structures/resources for IMCI (VHCs, CORPs)	MOH-Teso, Minstry of Culture and Social Services, WVK, Other district stakeholders					
Conduct training of VHCs, CORPs	MOH- Teso, AKHS, Dept Culture and Social Services, WVK					
Conduct Supportive supervision of VHCs and CORPs	MOH- Teso, WVK					
Develop and adopt District Behavior Change Communication Strategy (including developing/production of IECs)	MOH- Teso, DoMC, MOH-Div Health Education, WVK, AKHS, KEPI, DCH, PMO-Western Province					

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02				YEAR 2 Oct 02/ Sep 03				YEAR 3 Oct 03/ Sep 04				YEAR 4 Oct 04/ Sep 05				YEAR 5 Oct 05/ Sep 06			
2. HIV/AIDS/STI Control																					
Support district to strengthen HIV/AIDS/STI Surveillance system	NASCOP, MOH-Teso, WVK, DAC, Other partners																				
Support district to establish 2 VCT Centers	MOH-Teso, WVK, DAC, Partners																				
Strengthen community based responses to HIV/AIDS care and support	DAC, WVK, CBOs, Other partners																				
In conjunction with other stakeholders, equip young people(Children, adolescents, young adults) with life skills for prevention of HIV/AIDS and other Sexually Transmitted Infections.	DACC, WVK, Other Stakeholders																				
Train women/partners on safe sex practices including negotiation skills.	MOH-Teso, DACC, WVK, CBOs, Other Stakeholders																				
3. Immunizations and Vitamin A supplementation																					
Support district to set up and implement system for the maintenance of the cold chain	MOH-Teso, WVK, KEPI																				
Establish tracking system for monitoring vaccine “drop out”	MOH-Teso, WVK, KEPI, CORPs																				
Support health staff in identifying “missed opportunity” and training health staff to reduce “missed opportunities”.	MOH-Teso, KEPI, WVK																				
Participate in NIDS and surveillance	MOH-Teso, WVK, KEPI																				
Increase community demand for immunization services for infants and pregnant women by implementing Behavior Change Communication (BCC)	MOH-Teso, CORPs, WVK																				
Strengthen mechanisms for conducting regular monitoring and supervision of immunization activities	MOH-Teso, WVK																				
Support immunization outreach activities	MOH-Teso, WVK, Health Facility Committees																				
Vit A																					
Plan with stakeholders and Identify district strategy for accelerating implementation of national program for Vit. A Supplementation	MOH-Teso, KEPI, WVK																				
Implementation of strategy Vit. A Supplementation.	MOH-Teso, WVK, CORPs																				

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02	YEAR 2 Oct 02/ Sep 03	YEAR 3 Oct 03/ Sep 04	YEAR 4 Oct 04/ Sep 05	YEAR 5 Oct 05/ Sep 06
4. Control of Diarrheal Diseases (CDD)						
Training of health workers for improved case management of children suffering from diarrhea .	MOH-DCH, WVK, AMKENI					
Training of Trainers(CORPs) and communities/households on CDD focussing on key emphasis house hold behavior and practices. These practices include transmission, prevention and appropriate home management as well as care seeking behavior of diarrhea among children.	MOH-Teso, Partners, WVK					
Training of families/health messages on prevention of diarrhea, and management of children suffering from diarrhea.	MOH-Teso, WVK, Partners					
5. Pneumonia Case Management (PCM)						
Training of health workers for improved PCM including correct diagnosis and treatment and appropriate referral.	MOH-DCH, WVK, AMKENI					
Collaborate with District MOH to ensure availability of appropriate antibiotic through appropriate record keeping and monitoring of drug stock levels	MOH-Teso, MOH-DCH, WVK, Partners					
Training of Trainers (CORPs) and families/communities focussing on key family / household and community practices on appropriate care seeking, care and management of child/infant suffering from pneumonia.	MOH-Teso, WVK, Partners					
6. Control of Malaria						
Collaborate with District level Ministry of Health to ensure support and training for timely treatment and protective intermittent treatment for pregnant mothers (including anemia prevention).	MOH-Teso, MOH-DCH/DoMC WVK,AMKENI, District Stakeholders.					
Collaborate with District level Ministry of Health to ensure support and training for appropriate and timely malaria treatment among children and infants.	MOH-Teso, MOH-DCH/DoMC WVK,District Stakeholders.					

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02	YEAR 2 Oct 02/ Sep 03	YEAR 3 Oct 03/ Sep 04	YEAR 4 Oct 04/ Sep 05	YEAR 5 Oct 05/ Sep 06
Training of Trainers(CORPs) focussing on key family practices for malaria prevention among vulnerable groups (Use of ITNs)	MOH-Teso, WVK,District Stakeholders, Partners					
Work with Communities/families to adapt appropriate malaria prevention practices at household level, as well as appropriate care seeking and malaria case management.	MOH-Teso, WVK,District Stakeholders, Partners (PSI, Others)					
Identify supplier of ITN, train community groups and strengthen social marketing skills and strategies for ITN promotion.	MOH-Teso, DoMC,WVK,District Stakeholders, Partners (PSI, Others)					
Work with CORPs for the follow up of ITNs(use ,re-treatment, care).	MOH-Teso, WVK,District Stakeholders, Partners (PSI, Others)					
Behavior Change and Communication Strategy: Develop Health promotion strategy that will encompass Health Education, Social mobilization, IEC development/production, Social marketing and Advocacy.						
Establish the current health promotion activities in the district-existing IEC materials, actors as well as existing gaps.	MOH-Teso, MOH-DoMC/DHEO, District Stakeholders.					
Establish opportunities that can be used to scale up health promotion.	MOH-Teso, MOH-DoMC/DHEO, District Stakeholders.					
Identify the key actors and potential stakeholders for their involvement/participation in development and implementation of Health Promotion.	MOH-Teso, MOH-DoMC/DHEO, District Stakeholders.					
Identify mechanisms/means to build the capacity within the district for health promotion.	MOH-Teso, MOHDoMC/DHEO, District Stakeholders, WVK					
Reproduce/develop/produce and disseminate identified behavior change messages to community/families/identified target groups	MOH-Teso, MOH-DoMC/DHEO, District Stakeholders.					
Support Supervision						
Conduct joint monthly monitoring and supervision (Health facilities).	DHMT, WVK					

ACTIVITY	Implementing organization	YEAR 1 Oct 01/ Sep 02	YEAR 2 Oct 02/ Sep 03	YEAR 3 Oct 03/ Sep 04	YEAR 4 Oct 04/ Sep 05	YEAR 5 Oct 05/ Sep 06
Conduct joint monthly monitoring and supervision for CORPs	MOH-Teso, WVK					
Quality Improvement/Assurance						
Collaborate with District MOH to define and identify "Quality of Health Care Dimensions"	MOH-Teso, WVK, Partners					
Collaborate with Community level organizations/structures to define "Quality Dimensions" for Community/Household Level activities/interventions	MOH, Community level structures/organizations (VHCs, CORPs), Partners and WVK					
Implement and implement Quality Improvement/Assurance in all project activities as defined.	MOH, Community level structures(VHCs, CORPs), WVK					